

CASE REPORT FORM

Meningococcal Disease

	EpiSurv No.
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Reporting Authority		
Name of Public Health Officer responsible for case		
Notifier Identification (i)		
Reporting source* ☐ General Practitioner ☐ Hospital-based Practitioner ☐ Laboratory ☐ Self-notification ☐ Outbreak Investigation ☐ Other		
Name of reporting source	Organisation	
Date reported* dd/mm/yyyy	Laboratory sample date dd/mm/yyyy	Contact phone
Usual GP	Practice	GP phone
GP/Practice address Number Street Suburb Town/City Post Code ☐ GeoCode		
Case Identification (i)		
Name of case* Surname Given Name(s)		
NHI number* Email		
Current address* Number Street Suburb Town/City Post Code ☐ GeoCode		
Phone (home) Phone (work) Phone (other)		
Case Demography		
Location TA* DHB*		
Date of birth* dd/mm/yyyy OR Age ☐ Days ☐ Months ☐ Years		
Sex* ☐ Male ☐ Female ☐ Indeterminate ☐ Unknown		
Occupation* (i)		
Occupation location ☐ Place of Work ☐ School ☐ Pre-school		
Name		
Address Number Street Suburb Town/City Post Code ☐ GeoCode		
Alternative location ☐ Place of Work ☐ School ☐ Pre-school		
Name		
Address Number Street Suburb Town/City Post Code ☐ GeoCode		
Ethnic group case belongs to* (tick all that apply) (i)		
☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori		
☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan		
☐ Other (such as Dutch, Japanese, Tokelauan) *(specify)		

Basis of Diagnosis**CLINICAL CRITERIA**

Fits clinical description* ☐ Yes ☐ No ☐ Unknown 

Clinical features

Meningitis* ☐ Yes ☐ No ☐ Unknown *Septicaemia* ☐ Yes ☐ No ☐ Unknown

Petechial or purpuric rash* ☐ Yes ☐ No ☐ Unknown Other invasive illness* (specify)

Other clinical features

Gastrointestinal symptoms ☐ Yes ☐ No ☐ Unknown If yes, specify

Respiratory symptoms ☐ Yes ☐ No ☐ Unknown If yes, specify

LABORATORY CRITERIA

Isolation of *N.meningitidis* from CSF* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

Isolation of *N.meningitidis* from blood* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

Isolation of *N.meningitidis* from other site* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

(specify site*)

Detection of Gram-negative intracellular diplococci* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

(specify site*)

Detection of meningococcal antigen in CSF (latex test)* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

Detection of *N.meningitidis* DNA in blood* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

Detection of *N.meningitidis* DNA in CSF* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

Detection of *N.meningitidis* DNA in other site* ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results

(specify site*)

Other positive test* (specify)

CLASSIFICATION* ☐ Under investigation ☐ Probable ☐ Confirmed ☐ Not a case 

ADDITIONAL LABORATORY DETAILS

Group PorA type

Multi locus sequence type (MLST)

ESR Updated ☐ Laboratory

Date result updated dd/mm/yyyy  Sample number

Other laboratory details*

Clinical Course and Outcome

Date of onset* dd/mm/yyyy  ☐ Approximate ☐ Unknown

Time of onset* ☐ Unknown

Hospitalised* ☐ Yes ☐ No ☐ Unknown

Date hospitalised* dd/mm/yyyy  ☐ Unknown

Time Hospitalised* ☐ Unknown

Hospital*

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Clinical Course and Outcome continued																					
Died* ☐ Yes ☐ No ☐ Unknown																					
Date died* dd/mm/yyyy	☐ Unknown																				
Was this disease the primary cause of death?* ☐ Yes ☐ No ☐ Unknown																					
If no, specify the primary cause of death* 																					
Outbreak Details																					
Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?* ☐ Yes If yes, specify Outbreak No.* 																					
Risk Factors																					
Contact with a confirmed or probable case of meningococcal disease during the incubation period for this disease* ☐ Yes ☐ No ☐ Unknown																					
If yes, was prophylaxis offered?* ☐ Yes ☐ No ☐ Unknown																					
If yes, was prophylaxis taken?* ☐ Yes ☐ No ☐ Unknown																					
If yes, specify type of prophylaxis* (tick all that apply) ☐ Antibiotic ☐ Vaccine																					
EpiSurv number of confirmed or probable case*	 																				
Nature of contact with confirmed or probable case*	 																				
<i>(see contact management categories below)</i>																					
Attendance at school, preschool or childcare* ☐ Yes ☐ No ☐ Unknown																					
Was the case overseas during the incubation period for meningococcal disease?* ☐ Yes ☐ No ☐ Unknown																					
Other risk factors for meningococcal disease, specify* 																					
Protective Factors																					
At any time prior to onset, had the case been immunised with meningococcal vaccine?* ☐ Yes ☐ No ☐ Unknown																					
If yes, specify which vaccine* <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 15%;">No. of Doses*</th> <th style="width: 15%;">Date of Last Dose*</th> <th style="width: 30%;">Source of Information*</th> </tr> </thead> <tbody> <tr> <td>☐ Meningococcal B four-component recombinant</td> <td> </td> <td>dd/mm/yyyy </td> <td> ☐ Patient/caregiver recall ☐ Documented </td> </tr> <tr> <td>☐ Meningococcal ACWY conjugate</td> <td> </td> <td>dd/mm/yyyy </td> <td> ☐ Patient/caregiver recall ☐ Documented </td> </tr> <tr> <td>☐ Meningococcal group C conjugate</td> <td> </td> <td>dd/mm/yyyy </td> <td> ☐ Patient/caregiver recall ☐ Documented </td> </tr> <tr> <td>☐ Other (*specify) </td> <td> </td> <td>dd/mm/yyyy </td> <td> ☐ Patient/caregiver recall ☐ Documented </td> </tr> </tbody> </table>			No. of Doses*	Date of Last Dose*	Source of Information*	☐ Meningococcal B four-component recombinant	 	dd/mm/yyyy	☐ Patient/caregiver recall ☐ Documented	☐ Meningococcal ACWY conjugate	 	dd/mm/yyyy	☐ Patient/caregiver recall ☐ Documented	☐ Meningococcal group C conjugate	 	dd/mm/yyyy	☐ Patient/caregiver recall ☐ Documented	☐ Other (*specify) 	 	dd/mm/yyyy	☐ Patient/caregiver recall ☐ Documented
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Management																					
CASE MANAGEMENT																					
Were IV/IM antibiotics given prior to hospital admission?* ☐ Yes ☐ No ☐ Unknown																					
If yes, specify antibiotic and route ☐ Intravenous ☐ Intramuscular																					
If yes, date given* dd/mm/yyyy	☐ Date unknown Time given* ☐ Time unknown																				

		EpiSurv No. 			
Management continued					
CONTACT MANAGEMENT					
Type of contact	Number identified	Number offered abx	Number given abx	Number offered vaccination	Number vaccinated
Household contacts					
Childcare/pre-school contacts					
Close institutional contacts					
Contacts exposed to oral secretions					
Other close contacts					
(specify)					
If contacts were vaccinated, name of the vaccine(s) given					
Comments*					